Document Owner:	Reviewed By:	Approved By:
PP/Peds Manager	PP/PEDS Manager, FBC Perinatal RN Nav-Neonatal, FBC Nurse Clinician	Dir, Wmns & Childrens

	0800 (1000)	1200 (1400)	1600 (1800)	2000 (2200)	2400 (0200)	400 (0600)	Immediately	During Shift /Event	End of Shift	Comments/Tips:
OB/NEWBORN FLOWSHEET (SYSTEMS REVIEW)										
Admission							x			• Initial Assessment and Vital signs on both Mother and Baby on admission to PP within 1 hour • ID band check on admission, document in Newborn Flowsheet
Critical Labs							x			• Chart exact time of call, value & action. SBAR note if MD notified. • Clarify with PCF or Team Lead if any results questionable. • Do not use "Continue to Monitor" unless provider aware.
Echo Labs										
MD/Provider notify							x			• Must be documented even if MD is on unit: provider, reason, time, action.
Significant Event							x	x		• Chart precise start time of event/procedure otherwise.
Pain Mother	x		x		x			x		• Pain assessment with all frequent vitals: Vaginal Birth: On admission to unit, Q 4 hours x 2 then every shift (8hrs), Cesarean Birth: Q 30 minutes x 2, Q 1 hour x 2, Q 4 hours until 24 hours postop then every shift (8hrs), • If medication is given for pain, pain will be reassessed within 2 hours after of intervention in accordance with the care, treatment, and services provided. • After meds chart "reassessment", otherwise for routine "shift observations." • If sleeping after meds, use "reassessment" and "appears sleeping."

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OB/NEWBORN FLOWSHEET (SYSTEMS REVIEW)										
Pain Newborn-FLACC scale										• Pain assessment with all frequent vital signs assessment: every 30 minutes x4, every 4 hours x2, every 8 hours until discharge. • If medication is given for pain, pain will be reassessed within 2 hours after of intervention in accordance with the care, treatment, and services provided. • (If infant asleep after intervention, “appears sleeping” is acceptable as reassessment)
Psychosocial	x		x		x					
Cardiovascular	x		x		x					
DVT Prophylaxis	x		x		x					
Pulmonary &Anterior/Posterior Breath Sounds	x		x		x					• Need to be documented with each assessment. A "normal” assessment does not preclude need to chart breath sounds.
Gastrointestinal	x		x		x					• Document GI issue and effect of meds given (nausea, vomiting, diarrhea) • Document if patient requires peri cares greater than 2x/shift • Document bowel sounds x 4 quadrants for Post-op patients with each vitals check

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OB/NEWBORN FLOWSHEET (SYSTEMS REVIEW)										
Genitourinary	x		x		x					• Foley catheters are exceptions if they meet the criteria listed (urgency, dysuria, etc.) • Document foley insertion once (at time it is placed)
Musculoskeletal	x		x		x					• Chart gait with every assessment or PRN (changes) remembering "unsteady" is an exception • Chart Motor Movt each frequent vitals check with postoperative patients until full movt has been documented
Braden Scale	x		x		x					
Integumentary	x		x		x					• Document color, temp, moisture, appearance (if intact) with every assessment • Document incision assessment with each frequent vitals check
Head to Toe Skin	x		x		x					• Initial assessment on admission to PP.
Risk for Injury	x		x		x					• If risk for injury score is 1-4, implement Fall Prevention Interventions
Hendrich II- Falls	x		x		x					• If Hendrich score is 5 or greater, implement Fall Prevention Interventions • Initial Falls Assessment & Risk for Injury to be done within 12 hours of arrival • If a patient falls while in the hospital, remember to update the Hendrich score
Safety Intervention	x		x		x					• Interventions to be documented every 8 hours
Infection Risk	x		x		x					• Document Isolation type/Infection Risk to reflect acuity

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VASCULAR ACCESS FLOWSHEET										
IV Sites	xx	xx	xx	xx	xx	xx				• Monitor anytime you go in the room. Document every 2 hours.
Vascular Access	x	x	x	x	x	x				• Saline Lock is q 4 hrs, if there is a continuous infusion (central or peripheral) assess/document q2 hrs. Flush every 8 hrs minimum. Change site q 96 hrs.

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IV MAR FLOWSHEET										
IV MAR	700			1500			2300			• Add up all IV Fluids/total pumps and documents volumes. Chart "real time" and remember PCA's.
I/O FLOWSHEET										
I/O	x	x	x	x	x	x		x	x	• Document in "real time" throughout shift (voiding, emesis, stool). • Strict I & O with Postoperative foley placed • Document 2 voids (with amounts) post foley removal if adequate output • Document 2 voids after admission to postpartum (vaginal delivery) • Newborn: Latch score (if breastfeeding) every 8 hours
Drains/Foleys	700			1500			2300			• Drains/Foley's emptied every at the end of the shift.
PATIENT CARES/ADL's FLOWSHEET										
Interpreter							x			• Document time service called & arrived for each interpreter use.
Nutrition	x		x		x					
Safety	x		x		x					• Risk A (SBA)/Risk B (Post-op, PCA use, assistive device)/Risk C (confused, CIWA, Dementia, restraints) or anytime there is a change in status

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VITALS OB FLOWSHEET										
Vital Signs Mother	x		x		x		*	*		• Unless ordered differently by provider. ***Immediately if any change in condition.** • Follow Post op routines: Q 15 min x 8, Q 30 min x 2, Q 1 hr x 2, Q 4 hrs until 24 hours postop (VS within 2 hours of discharge) • Vaginal delivery: Q 15 min x 8, on admission to PP, Q 4 hr x 2, q 8 hrs until discharge (VS within 2 hours of discharge) • For BP chart cuff site, patient position and method (auto, manual).
VITALS NEWBORN FLOWSHEET										
Vital Signs Newborn										• **Term infant** : every 30 minutes x 4 (recovery), on admission to postpartum and then every 4 hours x2 and every 8 hours until discharge • **Late preterm infants**: less than 37 weeks (includes O2 sat and then every 30 minutes x4 (recovery), every one hour x2, every three to four hours with feeding until discharge (O2 sat checks every 4 hours x3 and then daily), (sats to remain > 92%) • **Mother GBS+** vitals every 4 hours until discharge after recovery vitals. **Notify MD with any abnormal values.** • **All newborns**: vitals within two hours of discharge.
Weight					x					• Newborn weights daily
Orthostatic VS								x		• If blood loss >1000ml for cesarean and >500 for vaginal delivery • If symptomatic and per provider order. Document by clicking "add row" and also in notes.

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CARE PLANS										
PP/Newborn	x		x		x			x		• Initiate within 4 hours and individualize to your patient • Prioritize & document goals every shift in a care plan progress note • Goals/interventions need to be resolved or addressed before discharge
PROGRESS NOTES										
PP/Newborn								x		• Admission to Postpartum/Normal Newborn, change in status, transfer, discharge, provider notification, panic/critical lab notification and action taken. (SBAR format).

TABLE OF REVISIONS

Date	Description of Change(s)
11/7/16	Updated pain under **OB/Newborn flowsheet (systems review)** according to the Pain Policy from 10/2016.